Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

_____
(Signature of Agency Head)

SCHIP Program Name(s): NH Healthy Kids

SCHIP Program Type:
- ____Medicaid SCHIP Expansion Only
- _____Separate SCHIP Program Only
- ___x_Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

Contact Person/Title: Kathleen A. Dunn, Director, Office Of Community and Public Health

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Submission Date: Jan 1st 2002

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This section has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility
NC

B. Enrollment process
NC

C. Presumptive eligibility
NC

D. Continuous eligibility
NC

E. Outreach/marketing campaigns
NC

F. Eligibility determination process
NC

G. Eligibility redetermination process
NC

H. Benefit structure
NC

I. Cost-sharing policies
NC

J. Crowd-out policies
NC

K. Delivery system
NC

L. Coordination with other programs (especially private insurance and Medicaid)
NC

M. Screen and enroll process
NC

N. Application
NC

O. Other

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

A. The estimated baseline number of uninsured low-income children is 26,000. Of those 16,576 are eligible for either Medicaid or the SCHIP program (Healthy Kids Gold and Healthy Kids Silver, respectively) and of those only 4,800 children are eligible for the Silver program. As of September 30, 2001 the State has enrolled a total of 2,907 children in the Healthy Kids Silver $20 program (+526 from FFY'00) and a total of 915 children in the Healthy Kids Silver $40 program (+262 from FFY'00). In addition 612 infants have been enrolled in the Healthy Kids Gold (CHIP Medicaid expansion).

The total number of children enrolled to date in the New Hampshire's Children's Health Insurance Program- Healthy Kids Gold and Silver as of September 30, 2001 has grown from nearly 10,000 to 14,815 in the past 12 months. Thus the proportion of all children who are uninsured has been reduced by 56%. The proportion of uninsured children who are eligible for one of the subsidized programs has been reduced by 89%.

The data source of the number of uninsured children in New Hampshire is a random, household telephone survey of 12,000 households in New Hampshire conducted by the NH Department of Health and Human Service's Office of Planning and Research under the direction of Steve Norton, Senior Analyst, formerly of the Urban Institute. The data source of enrolled children is actual enrollment numbers from the NH Healthy Kids Corporation, our administrator of the Healthy Kids Silver, (stand alone), component of the NH CHIP program and the Medicaid Administration Bureau.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

As of September 30 2001, 10,993 new children have been enrolled in the Healthy Kids Gold program. The data source is actual enrollment numbers from the state's eligibility system, New Heights.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

The State is in the process of completing the analysis of a second statewide household insurance survey, which was conducted during CY 2001 under the direction of Steve Norton, formerly of the Urban Institute.

Preliminary results indicate an overall decrease in the percentage of uninsured children in New Hampshire. The actual results should be available within the next month.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

a. x No, skip to 1.3

i. Yes, what is the new baseline?

E. What are the data source(s) and methodology used to make this estimate?

F. What was the justification for adopting a different methodology?

G. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

H. Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
Increase the number of low-income children who are insured	Decrease the proportion of children 1-19 years of age, ≤ 300% FPL who are uninsured by 25% in year one, 35% in year two, 45% in year three and 50% by year four.	Data Sources: NH Household Insurance Survey (1999); NH MMIS and NH Healthy Kids Corporation. (See attached Graphs) Methodology:Baseline = random household survey. Enrollment #'s = counting all children ever enrolled. Progress Summary: This objective has been met. As of 9/30/01 the number of uninsured children <300% FPL has been reduced by 89%.
Objectives Related to SCHIP Enrollment		
Maximize enrollment in Healthy Kids Gold and Silver.	Increase the number of locations where individuals can get applications and receive assistance in completing applications. Increase the number of entities participating in the outreach program. Increase the percentage of applications that are complete. Decrease the amount of follow up required to complete applications. Ensure that at least 75% of consumers are satisfied with the application process.	Data Sources: Methodology: Progress Summary: No change to report at this time although the state will be submitting a Title XXI State Plan amendment within the next 45 days which will impact this objective in a positive manner. One exception – attached is the first published report of the Quality in Children's Health Insurance Programs report. A consumer satisfaction survey was conducted and results indicate overwhelming majority of consumers are satisfied with the application process.

Objectives Related to Increasing Medicaid Enrollment		
Maximize coordination with the Medicaid program (now named Healthy Kids Gold).	Increase enrollment in Healthy Kids Gold by 10% in the first year of operations. Establish a seamless program with integrated staff and administration	Data Sources: NC Methodology: Progress Summary: This objective was met last year.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
		Data Sources: Methodology: Progress Summary:
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
Improve the health status of children in NH with a focus on preventive and primary care.	Match or exceed the current statewide avg. % of children under two who receive basic immunization series. Match or exceed the current statewide avg. % of 13 year olds who receive basic immunization series. Match or exceed the current statewide avg. % of 3,4,5 and 6 year olds who have at least one well-child visit during the year. Match or exceed the current statewide avg. % of 12-18 year olds who have at least one well-child visit during the year.	Data Sources: MMIS and Medicaid Managed Care HMO Methodology: Comparison of immunization rates with statewide average % = 86%. Comparison of well-child data from MCH and commercial insurers. Progress Summary: Since the FFY 2000 Annual Report the first QCHIP report has been published. A copy of the report can be found attached to this document. The QCHIP workgroup will use this as a foundation to creating health outcome objectives modeled after HEDIS measures. The QCHIP workgroup just received funding to continue its work in 2002. In addition, the DHHS is in the process of building a Medicaid Decision Support System (MDSS) which will allow for fast retrieval of preventive and primary care data. It is anticipated that the system will be functioning in SFY 03. The highlights of the QCHIP Report include: • Application and Enrollment Process – High Consumer Satisfaction. • Multiple sources of information about the program are key to successful outreach. • Renewal process smooth in comparison to other states. • SCHIP is an important long-term source of coverage in comparison to other states. • Compliance with Well Child Care Visits Very Good • Immunization rates – unable to calculate with current data • Very low occurrences of ambulatory care sensitive

		conditions. • Satisfaction with care very high.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

1.6.1 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

The program is of sufficient maturity now that a review of the performance objectives is warranted during this current fiscal year. This will be done under the auspices of the QCHIP workgroup.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Attachments – Graphs from NH Healthy Kids – a comprehensive series. Those noted below are highlighted as most pertinent to this report. (Attn: For the electronic version of this report – just click on the tab of the Excel Document as labeled below).

- Inquiry History
- Inquiries by Source As a Percentage Through 10/01
- New Monthly Enrollment Feb-99 Through Nov-01
- Silver New Enrollment Trends
- Gold Application Trends
- Enrollment History Past 12 Months
- Termination Reasons Subsidized Programs
- Monthly Disenrollments by Program
- Disenrollments as Percentage of Enrollment
- Top Disenrollment Reasons – Silver Program

Attachment – Quality In Children's Health Programs (QCHIP) Summary Report *New Hamsphire Healthy Kids Evaluation*

Attachment – NH DHHS CHIP Summit Workplan and Status Report, November 2000 – December 2001**.**

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out. N/A

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

_____Number of adults
_____Number of children

C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).
N/A

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

_____Number of adults
_____Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Crowd out it defined as the substitution of public coverage for private coverage. The policy instituted in New Hampshire to mitigate crowd out is to require a child to have been uninsured for 6 months before becoming eligible for Healthy Kids Silver, New Hampshire's SCHIP program.

B. How do you monitor and measure whether crowd-out is occurring?

We monitor crowd out by collecting information of current and past insurance coverage on every applicant.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Because New Hampshire requires children to be uninsured for six months unless good cause applies, there is little evidence of crowd-out. To date there have been only 3 families who elected to drop private insurance, wait out the 6 month period and enroll in the Healthy Kids program.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

NH has just the one policy and given the experience to date the State is in the process of submitting a Title XXI State Plan Amendment to seek approval to reduce the number of months from 6 to 3.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Historically, the most effective method of reaching families has been to distribute information through the schools. Healthy Kids Corporation has been covering kids since 1995 without direct government subsidies until the Title XXI plan was implemented in January 1999. Throughout these years, about one-third of families indicate they learned about the program through their child's school.

The focus of our strategy is to work with organizations that directly serve families and children. What has been most effective in this strategic is the use of Outreach Coordinators in the field who develop relationships with community partners and provide outreach support through training and promotional materials.

We see a growing number of referrals through word-of-mouth. We believe that providing fast, fair, friendly customer service to families is essential in generating the kind of family satisfaction that prompts friends, family and neighbors to encourage others to enroll.

We measure the effectiveness of our outreach campaigns by tracking a referral source on all families that inquire and apply. These statistics can be compiled and analyzed through database queries. We also include questions regarding outreach methods and messages in periodic surveys of enrollees, disenrollees and prospective enrollees.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

To truly determine your effectiveness in reaching specific populations, you must have information regarding the insurance status of those populations. Overall, our enrollee surveys have shown that we have a higher proportional number of minority enrollees than appear in the general population based on old census data. The 2000 census data is being analyzed in detail but preliminary results indicate that in fact we have a disproportionate number of minority children who are uninsured and not enrolled. This has become a focus for us during FFY 2002.

New Hampshire conducted a Household Insurance Survey of 12,000 families in September 1999. Data indicate a need to do a concentrated, one-to-one, community-based outreach effort in the rural parts of the state. Thus this too has become a focal point for us during this fiscal year.

C. Which methods best reached which populations? How have you measured effectiveness?

The school system remains our number one referral source for the program. It will be interesting to monitor the effectiveness of targeted outreach to minorities and families living in rural areas of the state with a very focused, community-based outreach effort.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

Re-determination is a simplified mail-in process. Families must complete and sign a new application and submit new income and deduction verifications, as well as any documentation for other changes such as address change or the age verification for a new child. For S-CHIP, families receive three contacts – letter, phone call, letter – to encourage them to renew. Special attention has been made to making the process and letters easy to understand. The effectiveness of the S-CHIP process is being reviewed to determine if resources exist to implement a similar strategy for Medical renewal. Currently Medicaid families receive a single letter notifying them of the need to renew. The actual renewal process is the same as S-CHIP, although Medicaid is case-managed by State Case Technicians and S-CHIP is managed by the Healthy Kids Corporation Customer Service Staff.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

__X__ Follow-up by caseworkers/outreach workers
__X__ Renewal reminder notices to all families
____ Targeted mailing to selected populations, specify population
____ Information campaigns
____ Simplification of re-enrollment process, please describe
__X__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe
____ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

See 2.5.1.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Multiple and personalized contacts to encourage renewal.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

For S-CHIP, we capture the reason for the disenrollment based on state eligibility information or parent declaration. In FFY 2001, 65% of children who were disenrolled continued to have coverage through Medicaid or private insurance. The actual number of children who continue to be insured may be higher since some families request disenrollment through a letter or message without stating a reason.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

There is a common application and redetermination procedure. The same verification requirements are used for both programs during application and renewal. There is no requirement for face-to-face interviews. As noted in 2.5.1, the difference is that redetermination for Medicaid includes a single letter with no follow-up. Three attempts are made to contact S-CHIP families.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

State Case Technicians are co-located at the Healthy Kids Corporation offices. Eligibility is determined through a single State system that qualifies a child for Medicaid or S-CHIP. If Medicaid eligible, the case opens. If S-CHIP eligible, the case pends awaiting enrollment (e.g. premium payment and selection of PCP). The referral to enroll is transmitted to New Hampshire Healthy Kids through a daily electronic data interface. The interface also transmits changes in status or family information or instructs Healthy Kids to disenroll S-CHIP children. Likewise, Healthy Kids uses the electronic data interface to inform the State eligibility system when a child has been enrolled (then the case opens) or if a child has been disenrolled. Data sent to the State by Healthy Kids Corporation is automatically processed by the eligibility system.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Medicaid eligibles are automatically enrolled in a fee for service program using a network of providers that contract with DHHS. Voluntarily, Medicaid clients may opt for managed care coverage through Anthem BlueCross BlueShield and since August 2000, North East Delta Dental for a pre-paid dental benefit. S-CHIP kids are automatically enrolled in an Anthem plan with virtually the same provider network as Medicaid managed care. Most of the primary and specialty care providers in the Anthem network also participate in the Medicaid fee for service program. There are differences in the mental health network between the managed care plans and the State network.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Disenrollees – The number of children disenrolled for nonpayment of premium is tracked. In FFY 2001 about 17% of disenrollees were terminated for nonpayment (up from 15% in FFY 2000) and has attributed to a default of only 2% of total family premiums. Studies in other states indicate that many of these families acquire other coverage and simply fail to notify the State. We will continue to seek ways to assess the relationship between premiums, affordability and disenrollment for nonpayment as earlier surveys indicate an inconsistency in what parents say they are willing to pay as noted below.

Eligibles but Not Enrolled – In this category, we have two groups. Prospective families are those who have requested an enrollment kit but did not apply. Declining families are those whose children have been deemed eligible for the S-CHIP but fail to enroll (i.e. pay their premium and select a PCP).

Prospectives – A 1999 survey of prospective families indicates that nearly half of those who inquired but did not enroll remain uninsured. Cost is indicated as the primary reason for not enrolling. This study indicated that 76% would be eligible for free coverage so there appears to be a disconnect between what

families expect to pay and what their cost-sharing would be.

Declining Families – The predominant characteristic of declining families is that they did not apply through the mail-in process. 98% of declining families are referred for enrollment through a District Office of Health and Human Services where they applied for coverage or renewed their Medicaid eligibility. Currently we do not know the percentage of new applicants versus renewing families. Of those who do not enroll but are deemed eligible, nearly 90% fail to respond to enrollment efforts which include a phone call and two letters. A 1999 survey of these families does include that premiums are a barrier for some families with 35% of families interviewed indicated they could not pay the minimum $20 premium (17% can't afford anything and 18% could afford $10). However, 43% indicate they could pay $20 or $25, and 22% indicate they could pay more.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

A study of the relationship between cost-sharing and utilization was planned for 2001. However, the Publishing of the QCHIP report took much longer than first anticipated due to a need to clean and verify data obtained from the MMIS system.

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Contracts currently provide for the submission of claims/encounter level data to evaluate access to and use of health care services.

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

S-CHIP utilization is reported on a quarterly basis by the health plan. Visits per thousand and cost for categories of care are reported and compared to the commercial clientele of the health plan. As previously noted, with the development of the MDSS system, the state should be able to report similar data out on the Healthy Kids Gold program as funded under Title XIX.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

Please see the attachment on the QCHIP Report previously noted.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

Criteria to discourage crowd-out by offering eligibility only to families whose children had been uninsured for six months is problematic. Thus the State is moving towards reducing this to 3 months. Also, many families who have sacrificed to provide high-deductible, catastrophic coverage for their families feel that Title XXI regulations are unfair to them. We encourage consideration of using Title XXI funding to provide preventive and primary medical and dental services to families who are under-insured.

Many young adults transitioning to work or continuing their education remain uninsured because Title XXI can only be extended to the age of 19.

B. Outreach

We continue to explore ways to improve outreach as the "easy" uninsured kids have been found. The challenge now is to determine who we have not reached and to develop initiatives that are culturally competent both in terms of ethnicity but also geography.

C. Enrollment

The data on the reduction in the number of uninsured children is a tribute to the success of our outreach efforts.

D. Retention/disenrollment – N/A

E. Benefit structure – N/A

F. Cost-sharing – N/A

G. Delivery system – N/A

H. Coordination with other programs – N/A

I. Crowd-out – See Eligibility

J. Other

In November 2000 the State held a CHIP Summit with the goal of identifying potential areas of improvement in the CHIP program. Attached is a summary workplan and status of the areas workgroup members recommended for changes. The State is in the process of submitting a Title XXI state plan amendment along with State administrative rule changes to address the issues noted on the workplan.

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

N*ote: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).*

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

1.6.1 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

The program is of sufficient maturity now that a review of the performance objectives is warranted during this current fiscal year. This will be done under the auspices of the QCHIP workgroup.

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B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

_____Number of adults
_____Number of children

C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).
N/A

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

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2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Crowd out it defined as the substitution of public coverage for private coverage. The policy instituted in New Hampshire to mitigate crowd out is to require a child to have been uninsured for 6 months before becoming eligible for Healthy Kids Silver, New Hampshire's SCHIP program.

B. How do you monitor and measure whether crowd-out is occurring?

We monitor crowd out by collecting information of current and past insurance coverage on every applicant.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Because New Hampshire requires children to be uninsured for six months unless good cause applies, there is little evidence of crowd-out. To date there have been only 3 families who elected to drop private insurance, wait out the 6 month period and enroll in the Healthy Kids program.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

NH has just the one policy and given the experience to date the State is in the process of submitting a Title XXI State Plan Amendment to seek approval to reduce the number of months from 6 to 3.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Historically, the most effective method of reaching families has been to distribute information through the schools. Healthy Kids Corporation has been covering kids since 1995 without direct government subsidies until the Title XXI plan was implemented in January 1999. Throughout these years, about one-third of families indicate they learned about the program through their child's school.

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We see a growing number of referrals through word-of-mouth. We believe that providing fast, fair, friendly customer service to families is essential in generating the kind of family satisfaction that prompts friends, family and neighbors to encourage others to enroll.

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To truly determine your effectiveness in reaching specific populations, you must have information regarding the insurance status of those populations. Overall, our enrollee surveys have shown that we have a higher proportional number of minority enrollees than appear in the general population based on old census data. The 2000 census data is being analyzed in detail but preliminary results indicate that in fact we have a disproportionate number of minority children who are uninsured and not enrolled. This has become a focus for us during FFY 2002.

New Hampshire conducted a Household Insurance Survey of 12,000 families in September 1999. Data indicate a need to do a concentrated, one-to-one, community-based outreach effort in the rural parts of the state. Thus this too has become a focal point for us during this fiscal year.

C. Which methods best reached which populations? How have you measured effectiveness?

The school system remains our number one referral source for the program. It will be interesting to monitor the effectiveness of targeted outreach to minorities and families living in rural areas of the state with a very focused, community-based outreach effort.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

Re-determination is a simplified mail-in process. Families must complete and sign a new application and submit new income and deduction verifications, as well as any documentation for other changes such as address change or the age verification for a new child. For S-CHIP, families receive three contacts – letter, phone call, letter – to encourage them to renew. Special attention has been made to making the process and letters easy to understand. The effectiveness of the S-CHIP process is being reviewed to determine if resources exist to implement a similar strategy for Medical renewal. Currently Medicaid families receive a single letter notifying them of the need to renew. The actual renewal process is the same as S-CHIP, although Medicaid is case-managed by State Case Technicians and S-CHIP is managed by the Healthy Kids Corporation Customer Service Staff.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

__X__ Follow-up by caseworkers/outreach workers
__X__ Renewal reminder notices to all families
____ Targeted mailing to selected populations, specify population
____ Information campaigns
____ Simplification of re-enrollment process, please describe
__X__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe
____ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

See 2.5.1.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Multiple and personalized contacts to encourage renewal.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

For S-CHIP, we capture the reason for the disenrollment based on state eligibility information or parent declaration. In FFY 2001, 65% of children who were disenrolled continued to have coverage through Medicaid or private insurance. The actual number of children who continue to be insured may be higher since some families request disenrollment through a letter or message without stating a reason.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

There is a common application and redetermination procedure. The same verification requirements are used for both programs during application and renewal. There is no requirement for face-to-face interviews. As noted in 2.5.1, the difference is that redetermination for Medicaid includes a single letter with no follow-up. Three attempts are made to contact S-CHIP families.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

State Case Technicians are co-located at the Healthy Kids Corporation offices. Eligibility is determined through a single State system that qualifies a child for Medicaid or S-CHIP. If Medicaid eligible, the case opens. If S-CHIP eligible, the case pends awaiting enrollment (e.g. premium payment and selection of PCP). The referral to enroll is transmitted to New Hampshire Healthy Kids through a daily electronic data interface. The interface also transmits changes in status or family information or instructs Healthy Kids to disenroll S-CHIP children. Likewise, Healthy Kids uses the electronic data interface to inform the State eligibility system when a child has been enrolled (then the case opens) or if a child has been disenrolled. Data sent to the State by Healthy Kids Corporation is automatically processed by the eligibility system.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Medicaid eligibles are automatically enrolled in a fee for service program using a network of providers that contract with DHHS. Voluntarily, Medicaid clients may opt for managed care coverage through Anthem BlueCross BlueShield and since August 2000, North East Delta Dental for a pre-paid dental benefit. S-CHIP kids are automatically enrolled in an Anthem plan with virtually the same provider network as Medicaid managed care. Most of the primary and specialty care providers in the Anthem network also participate in the Medicaid fee for service program. There are differences in the mental health network between the managed care plans and the State network.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Disenrollees – The number of children disenrolled for nonpayment of premium is tracked. In FFY 2001 about 17% of disenrollees were terminated for nonpayment (up from 15% in FFY 2000) and has attributed to a default of only 2% of total family premiums. Studies in other states indicate that many of these families acquire other coverage and simply fail to notify the State. We will continue to seek ways to assess the relationship between premiums, affordability and disenrollment for nonpayment as earlier surveys indicate an inconsistency in what parents say they are willing to pay as noted below.

Eligibles but Not Enrolled – In this category, we have two groups. Prospective families are those who have requested an enrollment kit but did not apply. Declining families are those whose children have been deemed eligible for the S-CHIP but fail to enroll (i.e. pay their premium and select a PCP).

Prospectives – A 1999 survey of prospective families indicates that nearly half of those who inquired but did not enroll remain uninsured. Cost is indicated as the primary reason for not enrolling. This study indicated that 76% would be eligible for free coverage so there appears to be a disconnect between what

families expect to pay and what their cost-sharing would be.

Declining Families – The predominant characteristic of declining families is that they did not apply through the mail-in process. 98% of declining families are referred for enrollment through a District Office of Health and Human Services where they applied for coverage or renewed their Medicaid eligibility. Currently we do not know the percentage of new applicants versus renewing families. Of those who do not enroll but are deemed eligible, nearly 90% fail to respond to enrollment efforts which include a phone call and two letters. A 1999 survey of these families does include that premiums are a barrier for some families with 35% of families interviewed indicated they could not pay the minimum $20 premium (17% can't afford anything and 18% could afford $10). However, 43% indicate they could pay $20 or $25, and 22% indicate they could pay more.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

A study of the relationship between cost-sharing and utilization was planned for 2001. However, the Publishing of the QCHIP report took much longer than first anticipated due to a need to clean and verify data obtained from the MMIS system.

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Contracts currently provide for the submission of claims/encounter level data to evaluate access to and use of health care services.

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

S-CHIP utilization is reported on a quarterly basis by the health plan. Visits per thousand and cost for categories of care are reported and compared to the commercial clientele of the health plan. As previously noted, with the development of the MDSS system, the state should be able to report similar data out on the Healthy Kids Gold program as funded under Title XIX.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

Please see the attachment on the QCHIP Report previously noted.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

Criteria to discourage crowd-out by offering eligibility only to families whose children had been uninsured for six months is problematic. Thus the State is moving towards reducing this to 3 months. Also, many families who have sacrificed to provide high-deductible, catastrophic coverage for their families feel that Title XXI regulations are unfair to them. We encourage consideration of using Title XXI funding to provide preventive and primary medical and dental services to families who are under-insured.

Many young adults transitioning to work or continuing their education remain uninsured because Title XXI can only be extended to the age of 19.

B. Outreach

We continue to explore ways to improve outreach as the "easy" uninsured kids have been found. The challenge now is to determine who we have not reached and to develop initiatives that are culturally competent both in terms of ethnicity but also geography.

C. Enrollment

The data on the reduction in the number of uninsured children is a tribute to the success of our outreach efforts.

D. Retention/disenrollment – N/A

E. Benefit structure – N/A

F. Cost-sharing – N/A

G. Delivery system – N/A

H. Coordination with other programs – N/A

I. Crowd-out – See Eligibility

J. Other

In November 2000 the State held a CHIP Summit with the goal of identifying potential areas of improvement in the CHIP program. Attached is a summary workplan and status of the areas workgroup members recommended for changes. The State is in the process of submitting a Title XXI state plan amendment along with State administrative rule changes to address the issues noted on the workplan.

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

N*ote: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).*

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care	$3,872,257	$5,244,579	$6,104,570
per member/per month rate X # of eligibles			
Fee for Service	$158,610	$277,243	$302,264
Total Benefit Costs	$4,030,867	$5,521,822	$6,407,264
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	$4,030,867	$5,521,822	$6,407,264
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	$447,874	$613,536	$711,918
10% Administrative Cost Ceiling	$447,874	$613,536	$711,918
Federal Share (multiplied by enhanced FMAP rate)	$2,911,182	$3,987,983	$4,627,468
State Share	$1,567,559	$2,147,375	$2,491,714
TOTAL PROGRAM COSTS	$4,478,741	$6,135,358	$7,119,182

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__X__State appropriations
_____County/local funds
_____Employer contributions
__X__Foundation grants
_____Private donations (such as United Way, sponsorship)
_____Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

The Healthy NH Foundation has provided the majority of the 35% state match since the inception of the program. The growth in the program has outstripped the ability of the Foundation to continue to fully fund the state match. As such, this past fiscal year was spent securing a general fund appropriation from the legislature for the state match. The Department was successful in obtaining the match through June 30, 2004.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name	HEALTHY KIDS GOLD	HEALTHY KIDS SILVER
Provides presumptive eligibility for children	_____No __x__Yes, for whom and how long?	___X__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No __X__Yes, for whom and how long?	___X__No _____Yes, for whom and how long?
Makes eligibility determination	___X__State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	__X___State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*
Average length of stay on program	Specify months___4.5	Specify months _9.5
Has joint application for Medicaid and SCHIP	_____No __X__Yes	_____No __X___Yes
Has a mail-in application	_____No __X__Yes	_____No ___X__Yes
Can apply for program over phone	___X__No _____Yes	___X__No _____Yes
Can apply for program over internet	__X___No _____Yes	___X__No _____Yes
Requires face-to-face interview during initial application	___X__No _____Yes	__X___No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	___X__No _____Yes, specify number of months What exemptions do you provide?	_____No __X___Yes, specify number of months What exemptions do you provide? Good cause waivers for involuntary quit and certain voluntary quits.

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides period of continuous coverage regardless of income changes	__x__No _____ Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period	__x__No _____Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	__x__No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	_____No __x__Yes, how much? __$20 or $40 depending on income. Who Can Pay? ___ Employer __X_ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)
Imposes copayments or coinsurance	__x__No _____Yes	_____No __x__Yes
Provides preprinted redetermination process	__x__ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	__x__ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The initial application process involves sending in the completed application along with verification of income and deductions, proof of child(ren)'s birth age, proof of address, and picture id of at least one parent. Re-determination is a simplified mail-in process. Families must complete and sign a new application and submit new income and deduction verifications, as well as any documentation for other changes such as address change or the age verification for a new child.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

____% of FPL for children under age _____
_185% of FPL for children aged 1-19_____
____% of FPL for children aged _____

Medicaid SCHIP Expansion

0-300% of FPL for children age 0-1
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

_185-300 % of FPL for children aged 1-19
____% of FPL for children aged _____
____% of FPL for children aged_____

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes __X_ No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$90/worker	$90/worker	$90/worker
Self-employment expenses	$ Cost of doing	$ Business	$ Same
Alimony payments Received	$ N/A	$ N/A	$ N/A
Paid -**Court ordered**	$ Full amount	$ Full Amount	$ Full Amount
Child support payments Received	$ N/A	$ N/A	$ N/A
Paid – **Court ordered**	$ Full amount	$ Full Amount	$ Full Amount
Child care expenses	$200/175 FT $100/87.5 PT	$200/175 FT $100/87.5 PT	$200/175 Fulltime $100/87.5 Part time
Medical care expenses	$ N/A	$ N/A	$ N/A
Gifts	$ N/A	$ N/A	$ N/A
Other types of disregards/deductions (specify)	$ Garnishments to income allocated to dependents.	$ Garnishments to income allocated to dependents.	$ Garnishments to income allocated to dependents.

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

_X__No ___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

__X__No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

___X_No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

___ Yes __X_ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002 (10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage - State continues to evaluate this option.

B. Employer sponsored insurance buy-in – State continues to evaluate this option.

C. 1115 waiver – State continues to evaluate this option.

D. Eligibility including presumptive and continuous eligibility – See CHIP Summit summary for recommended changes.

E. Outreach – Hope to add evening hours to the central mail-in unit.

F. Enrollment/redetermination process – See CHIP Summit summary for recommended changes.

G. Contracting

Negotiating an affordable rate with the one insurer willing to underwrite the Healthy Kids programs (both Gold and Silver) is becoming a challenge with double digit increases in monthly premiums.

H. Other

See CHIP Summit summary for recommended improvements to the application and good cause waiver language.

On November 1, 2000, DHHS convened a "CHIP Summit" to identify barriers to NH's CHIP program and identify ways to overcome them and strengthen the overall program. Attending the Summit were DHHS staff, Covering Kids NH staff, NH Healthy Kids staff and the Executive Director of the Healthy New Hampshire Foundation. Five workgroups were formed to work on the following topics; **required documentation, the application, good cause waivers, continuous eligibility, and presumptive eligibility**. Workgroups, which have met over the past eight months, have made substantial progress and recommended positive changes to the policies and practices of the NH Healthy Kids program. All recommendations have been finalized and approved by either the Commissioner of DHHS and or Directors of OCPH and DFA. Next steps are outlined in the workplan.

Workgroup	Goal	Progress	Final Deliverable
Documentation	After researching what other states require and examining our requirements along with trends of frequently missing verification, bring forward a recommendation on what kind of documentation should be required when applying for NH HK.	Workgroup submitted ***recommendation to Commissioner- Commissioner approved most of the workgroup's recommendations.***	• **Picture ID requirement will be eliminated** • **Self declaration for proof of child care and, legal wage garnishment expenses** • **Self declaration for proof of incoming child support** • **Will clarify options for residency such as bills-** i.e. electric, cable, car registration, etc
Application	Revise the application based on recommendations made by Donna Cohen Ross from the Center for Budget Priorities and other changes necessary to make the application clear and concise.	Applications approved by Directors of OCPH and DFA	**Drafted a simplified form of original application and renewal application. Incorporated comments from national workgroup and simplified language. Application was carefully reviewed by CHIP Outreach group and Donna Cohen Ross.**
Prior Insurance and Good Cause Waivers	Based on comments from CHIP Summit, recommend reducing period of time required for child to go without insurance and also revise current good cause waivers and make recommendations for additional waivers.	Workgroup completed recommendation. Commissioner approved recommendation.	**Reducing period that child needs to be without insurance from 6 to3 months.** **Will add waivers to include circumstances such as** • **Domestic violence** • **Temporary Insurance coverage/ Cobra coverage** • **Non-custodial parent drops coverage** • **Parent leaves employment to stay at home with pre-school**

			age children **Will also revise language of current rules**
Continuous Eligibility/	Bring forward recommendation on whether NH should enact continuous eligibility for one year regardless of income. Look at costs and potential caseloads.	Workgroup completed recommendation. Director of OCPH approved recommendation.	**Recommendation: Dept moves to 12 months when the budget will allow for us to do so.**
Presumptive Eligibility	Recommend changes in PE infrastructure and draft policy on curriculum, training, evaluation.	Workgroup completed recommendation. Director of OCPH approved recommendation.	**Workgroup has recommended changes to infrastructure and created quality assurance components. Workgroup also recommended centralizing all presumptive eligibility applications and community facilitated application to the mail in-unit at NH Healthy Kids. Drafted policy and training curriculum. Created workplan to phase in components.**